



**KENTUCKY BOARD OF  
EMERGENCY MEDICAL SERVICES**

COMMONWEALTH OF KENTUCKY  
2545 LAWRENCEBURG ROAD  
FRANKFORT, KENTUCKY 40601  
PHONE: 502-564-8963  
FAX: 502-564-4687



**CRITICAL CARE ENDORSEMENT  
TRAINING PROGRAM VERIFICATION FORM**

*This form completes requirement number 3 on the Critical Care Endorsement Requirements Checklist.*

*A paramedic licensed by the board may be granted a critical care endorsement upon presentation of a board approved application and completion of a training program that minimally meets the objectives of the University of Maryland Baltimore Campus CCEMTP Program.*

*The ambulance service director and EMS medical director shall validate verification of the program having met the specified training standards.*

**Paramedic Name:** \_\_\_\_\_  
*Last, First Middle*

**Paramedic Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Date:** \_\_\_\_\_

**Name of Training Agency:** \_\_\_\_\_

**Course Location:** \_\_\_\_\_

**Course Completion Date:** \_\_\_\_\_

**MEDICAL DIRECTOR & INSTRUCTOR VERIFICATION SECTION**

I, \_\_\_\_\_, hereby certify that the above paramedic has  
*Printed name of Medical Director*  
completed a training program that minimally meets the objectives of the University of Maryland Baltimore Campus CCEMTP Program.

\_\_\_\_\_  
*Signature of Medical Director*

**SERVICE DIRECTOR VERIFICATION SECTION**

I, \_\_\_\_\_, hereby certify that the above paramedic has  
*Printed name of Service Director*  
completed a training program that minimally meets the objectives of the University of Maryland Baltimore Campus CCEMTP Program.

\_\_\_\_\_  
*Signature of Service Director*